U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 12 April 2007

Case No. 2003-BLA-5520

In the Matter of:
R.B.,[1]
Claimant,

v.

PLEASANTVIEW MINING CO., INC.
Employer,
and
AMERICAN INTERNATIONAL SOUTH
INSURANCE CO.
Carrier,
and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
Thomas M. Rhoads, Esq.
For the Claimant

Sherri P. Brown, Esq.
For the Employer

Sarah M. Hurley, Esq.
For the Director

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER ON REMAND – AWARD OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act

[1] Effective August 1, 1006, the Department of Labor directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site and to insert initials of such claimant/parties in the place of those proper names. In support of this policy change, DOL has adopted a rule change to 20 C.F.R. Section 725.477, eliminating a requirement that the names of the parties be included in decisions. Also, to avoid unwanted publicity of those claimants on the web, the Department has installed software

of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[2]

On December 21, 2004, the undersigned Administrative Law Judge issued a decision and order awarding benefits. The undersigned also issued a decision and order denying Employer's motion for reconsideration on March 15, 2005. On appeal, the decision was vacated and the case was remanded by decision and order of the Benefits Review Board ("Board"). *Brasher v. Pleasant View Mining Inc.*, 23 BLR 1-141 (2006), BRB No. 05-0570 BLA (Apr. 28, 2006).

ISSUES

The issues in this case are:

1. Whether Claimant has pneumoconiosis as defined by the Act;

2. Whether the Claimant's pneumoconiosis arose out of coal mine employment;

3. Whether the Claimant is totally disabled; and

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that prevents entry of the claimant's full name on final decisions and related orders. This change contravenes the plain language of 5 U.S.C. 552(a)(2) (which requires the internet publication), where it states that "in ***each case*** the justification for the deletion [of identification] shall be explained fully in writing." (*emphasis added*). The language of this statute clearly prohibits a "catch all" requirement from the OALJ that identities be withheld. Even if §725.477(b) gives leeway for the OALJ to no longer publish the names of Claimants – 5 U.S.C. 552(a)(2) clearly requires that the deletion of names be made on a case by case basis.

I also strongly object to this policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank,* 951 F. 2d 320 (11th Cir. 1992) and those collected at 27 Fed. Proc., L. Ed. Section 62:102 (Thomson/West July 2005). This change in policy rebukes the long standing legal requirement that a party's name be anonymous only in "*exceptional cases*." *See Doe v. Stegall*, 653 F.2d 180, 185 (5th Cir. 1981), *James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 1993), *and Frank* 951 F.2d at 323 (noting that party anonymity should be rarely granted)(*emphasis added*). As the Eleventh Circuited noted, "[t]he ultimate test for permitting a plaintiff to proceed anonymously is whether the plaintiff has a substantial privacy right which outweighs the customary and constitutionally-embedded presumption of openness in judicial proceedings." *Frank*, 951 F.2d at 323.

Finally, I strongly object to the specific direction by the DOL that Administrative Law Judges have a "mind-set" to use the complainant/parties' initials if the document will appear on the DOL's website, for the reason, *inter alia,* that this is not a mere procedural change, but is a "substantive" procedural change, reflecting centuries of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge's decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial "mind-set" constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. § 725.455(b), not merely that presently contained in 20 C.F.R. § 725.477 to state such party names.

[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

4. Whether the Claimant's total disability is due to pneumoconiosis.

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

R.B. ("Claimant") filed his claim for benefits under the Act on February 12, 2001. (DX 2).[3] The Director, Office of Worker's Compensation Programs ("OWCP"), issued a Proposed Decision and Order Award of Benefits on September 14, 2002. (DX 34). Employer timely requested a formal hearing before the Office of Administrative Law Judges. (DX 35). The undersigned issued a decision and order awarding benefits on December 21, 2004. (ALJX 1).[4] A subsequent motion for reconsideration was denied on March 15, 2005. (ALJX 2).[5]

Employer appealed the decision awarding benefits to the Benefits Review Board. In a decision dated April 28, 2005, the Board reversed and remanded the case for further consideration consistent with its opinion. *Brasher*, 23 BLR 1-141.

Length of Coal Mine Employment and Responsible Operator

As my previous findings of length of coal mine employment and responsible operator have not been challenged, I hold to my previous findings of thirty years of coal mine employment and Pleasantview Mining as the responsible operator in this case.

Claimant's last employment was in the Commonwealth of Kentucky. (DX 4). Therefore, the law of the Sixth Circuit is controlling.[6]

Benefits Review Board Instructions

In my previous decision and order, I determined that the good cause issue for exceeding the evidentiary limitations was waived by the parties for failure to present any argument before the court. The Board affirmed this portion of the decision. More specifically, the Board determined that an administrative law judge is not required *sua sponte* to conduct an independent

[3] In this Decision, "DX" refers to the Director's Exhibits, "CX" refers to the Claimant's Exhibits, "EX" refers to the Employer's Exhibits, "Tr." refers to the official transcript of this proceeding, and "ALJX" refers to Administrative Law Judge Exhibits.

[4] I now admit my previous decision and order into evidence and designate it as ALJX 1.

[5] I now admit the decision and order denying the motion for reconsideration and designate it as ALJX 2.

[6] Amherst Coal Co. is the designated responsible operator in this case. Miner worked for Amherst Coal Co. for ten years at its West Virginia facility. Miner's last coal mine employment, however, was with Oakley Coal Co., where he worked for approximately ten months at their Kentucky facility. Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

assessment as to whether or not "good cause" justified the admission of evidence in excess of the evidentiary limitations articulated under § 725.414. *Brasher* at 1-145-46 n. 3.

The Board went on to state that my decision to exclude all evidence in certain categories because evidence was submitted in excess of that permitted by the regulations was in error. Thus, I am to examine two arterial blood gas studies submitted by Claimant and Employer. *Id.* at 1-146. Also, I am to allow the Employer to submit two medical opinions as set forth in § 725.414. *Id.* at 1-146-47.

The Board affirmed my findings that Employer improperly exceeded its quantity of x-ray submissions in regard to Dr. Majmudar's positive interpretation of Claimant's April 4, 2001 x-ray submission. Employer submitted interpretations by Drs. Wiot and Broudy when it was only entitled to submit one reading in rebuttal under the regulations. *Id.* at 1-147. Thus, on remand, I am to consider only one of these readings in rebuttal. Furthermore, the Board intimated that my determination of which rebuttal x-ray is permitted may determine the weight given to a physician's opinion if he/she considered the inadmissible x-ray. *Id.* at 1-147-48 n.7.

In a case where a responsible operator has been designated, the district director may not submit more than one pulmonary function study. *Id.* at 1-149 n.11. As such, I have been instructed to consider the admissibility of a second pulmonary function study submitted by the director, which was conducted on May 16, 2001 identified as DX 9. *Id.* at 1-149.

Considering the admission of Dr. Broudy's 2001 and 2002 physical examination reports, the Board affirmed my finding that they constitute two separate medical reports for purposes of Employer's affirmative case evidentiary limitations under § 725.414. *Id.* at 1-146. On remand, the Board instructed me to consider the admissibility of Dr. Broudy's supplemental report and the weight to be given to it. *Id.* at n.5. Furthermore, the Board held that I erred in excluding Dr. Broudy's deposition testimony under § 725.414(c). *Id.* at 1-147 n.6.

The Board has also instructed that I am to consider the amount of inadmissible evidence considered in Dr. Chavda's deposition and weigh his opinion accordingly under *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004)(*en banc*). *Id.* at 1-148.

The Board also instructed that I am to address whether Dr. Lane's positive interpretation of an April 15, 1996 x-ray and Dr. Goldwin's positive interpretation of an August 23, 2000 x-ray should be excluded pursuant to § 718.102(d) on the basis that Claimant did not make the original films of these x-rays available for review. *Id.* at 1-149. The Board noted that should I consider these x-rays to not be part of the record, I may accord less weight to medical opinions that relied upon the x-rays.

In accordance with the above, the Board vacated all of the findings on the merits contained in the December 21, 2004 decision and order and remanded this claim for reconsideration of which evidence is properly admissible in light of the evidentiary limitations set forth at 20 C.F.R. § 725.414.

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under Sections 725.414(a)(2)(i) and (3)(i) or Section 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of Section 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under Section 725.414. § 725.406(b).

I incorporate by reference, as if fully set forth herein, the descriptions of medical evidence contained in my December 21, 2004 decision and order awarding benefits. (ALJX 1). Therefore, I will not disturb the factual descriptions of the original evidence, but will refer to it as necessary to resolve the claim now before me.[7]

The evidence from the OWCP examination (DX 7) is still admissible under § 725.414. Therefore the x-ray report, PFT, ABG, and medical report of Dr. Majmudar dated April 4, 2001 shall be considered in this claim.[8]

Claimant originally submitted the x-ray interpretations of Drs. Lane and Goldwin as initial evidence. In their post-remand brief, Claimant failed to mention any changes he wished to make in the designation of evidence. In fact, Claimant failed to mention any x-rays at all. Therefore, I shall consider the original x-ray submissions in this instance as well.

Concerning the above x-rays, the Board instructed that I should consider their admissibility in light of the fact the originals were not provided to other parties for review. Section 718.102(d) states that "[t]he original film on which the x-ray report is based *shall* be supplied to the Office, unless prohibited by law." (*emphasis added*). As the original x-rays were not provided to the Office of the Director so other parties could have it available for review, I find that the x-ray reports of Drs. Lane and Goldwin are inadmissible under § 718.102(d). Therefore, they shall not be considered in this claim.

[7] Evidence not considered or outlined in the previous decision and order will be outlined in the instant case.
[8] The second PFT dated May 16, 2001 has been deemed inadmissible. *Infra*.

In Employer's brief, it submitted that Dr. Wiot's readings of the July 2, 2001 x-ray and the January 7, 2002 x-ray as initial evidence. (EX 1 & 2). Furthermore, it submits Dr. Wiot's reading of the April 4, 2004 x-ray as rebuttal to the OWCP evaluation. These x-ray submissions comply with the evidentiary limitations set forth at § 725.414 and shall be considered in this claim.

The Director originally submitted a second pulmonary function study dated May 16, 2001. (DX 1). The Board instructed me to consider the admissibility of this PFT under § 718.414. Because the Director has identified a responsible operator, he is not entitled to exercise the rights of a responsible operator in regards to submitting evidence. Therefore, the submission of this second pulmonary function test exceeds the Director's rights in this case and it shall not be considered.

Concerning the PFT evidence submitted by the parties, Claimant originally submitted Dr. Mallampalli's study dated August 23, 2000 (DX 23), and Dr. Broudy's study dated July 2, 2001 as initial evidence. (DX 18). Employer listed the March 13, 2003 report of Dr. Burki in rebuttal of the August 23, 2000 PFT (EX 3), and the April 28, 2001 report of Dr. Burki in rebuttal of the April 4, 2001 OWCP PFT.[9] Employer also makes reference to Dr. Mallampalli's August 23, 2003 study. Also contained in the record are the two PFTs conducted by Dr. Chavda dated February 25, 1999 and May 18, 2000 in Claimant's treatment records.[10] (DX 23). The above evidence is in compliance with the evidentiary limitations of § 725.414 and shall be considered in this claim.[11]

On remand, the Employer stated it wished to submit the ABGs conducted by Dr. Broudy dated July 2, 2001 and January 7, 2002 as initial evidence. It also acknowledged the ABG conducted by Dr. Majmudar on April 4, 2001. This submission complies with the evidentiary limitations of § 725.414 and shall be considered in this claim. Claimant originally submitted three ABGs as initial evidence, which I determined to be in excess of the evidentiary limitations. Claimant has failed to address this issue on remand. However, the only ABG originally submitted by Claimant which was not submitted by the Employer as initial evidence is Dr. Malampalli's ABG dated August 23, 2000. (DX 23). The admission of this ABG complies with the evidentiary limitations set forth at § 725.414.[12] Therefore, it shall be considered in this claim.

The medical reports originally submitted by Employer were in excess of the evidentiary limitations at § 725.414. Specifically, I found that the submission of Dr. Broudy's two studies from July 2, 2001 and January 7, 2002 constituted two different reports. The Board affirmed this finding. *Brahser* at 1-146-47. Employer listed that it wished to rely upon the reports from July

[9] By unpublished decision in *Henley v. Cowin & Co*., BRB No. 05-0788 BLA (May 30, 2006), the Board held that the provisions at § 725.414 do not allow for the rebuttal of treatment records. Even though the August 23, 2000 PFT is a part of Claimant's treatment records, since Claimant has submitted this PFT as initial evidence, I find it is subject to rebuttal.

[10] Under *Henley*, these PFT studies are not subject to rebuttal.

[11] Employer also originally listed the July 4, 2001 report of Dr. Burki in rebuttal of the May 16, 2001 PFT submitted by the Director. As this PFT is not in evidence, a report in rebuttal is unnecessary.

[12] I note this ABG could also be admitted under Claimant's treatment records, as it appears to be taken in conjunction with Claimant's treatment under Dr. Chavda. (DX 23).

2, 2001, January 7, 2002 and January 11, 2002 report.[13] Therefore, absent other direct language from the Employer, I interpret this as Employer's wish to rely upon Dr. Broudy's July 2, 2001, and January 7, 2002 reports, so that it may comply with the evidentiary limitations under § 725.414. Employer also originally submitted two depositions by Dr. Broudy regarding these reports and did so again on remand. These depositions comply with the requirements set forth at § 725.414(c) and are therefore admissible.

Claimant originally submitted the medical reports issued by Dr. Chavda. (DX 23). I find that these records do not constitute a single report as outlined under § 725.414(a)(1), but rather constitute medical records under § 725.414(a)(4). I find this because these records do not show a single opinion based upon a one time treatment, but rather outline a history of visits Claimant had with Dr. Chavda over more than a four year period. The records were written contemporarily with each visit, and not after Dr. Chavda had a complete picture of Claimant's health. As such, I find these records are admissible under § 725.414(a)(4) as Claimant sought Dr. Chavda's treatment for a pulmonary condition. Furthermore, the admission of his deposition testimony complies with the requirements of § 725.414(c). (CX 1).

Finally, the Board asked me to consider the admissibility of Dr. Broudy's "supplemental" report dated January 11, 2002. *Brasher* at 1-146 n.5. In this report, Dr. Broudy provides a review of the records from the Western Kentucky Pulmonary Clinic as well as other hospital records. (DX 28). By unpublished decision in *Henley v. Cowin & Co.*, BRB No. 05-0788 BLA (May 30, 2006), the Board held that the provisions at § 725.414 do not allow for the rebuttal of treatment records.[14] Therefore, as this report is entirely a rebuttal of these treatment records, with the exception of the records Claimant submitted as initial evidence, I find this report inadmissible and accord it no weight.

Treating Physician

Claimant stated that Dr. Chavda served as his pulmonary specialist for approximately four and a half years, beginning in 1999. (Tr. 31). I previously found Dr. Chavda to be Claimant's treating physician, and this decision was not disturbed on appeal. Therefore, based upon the evidence and testimony, I find again find Dr. Chavda qualifies as Claimant's treating physician. (DX 23; Tr. 31).

X-RAYS

Exhibit	**Date of X-ray**	**Date of Reading**	**Physician / Credentials**	**Interpretation**
DX 7	4/04/01	4/04/01	Majmudar	1/1; p; 4 zones
DX 11	4/04/01	4/30/01	Sargent, BCR, B-reader	Quality 3, underexposed and underpenetrated
EX 2	4/04/01	5/15/02	Wiot/BCR, B-reader	Quality 3; Negative

[13] I assume Employer still considers this report to be a "supplemental" report. It shall be discussed *infra*.
[14] To the extent that this report rebuts PFT evidence which Claimant submitted as initial evidence under § 725.414, it shall be considered under rebuttal of PFT evidence, but only for that purpose.

EX 1	7/2/01	4/14/03	Wiot/BCR, B-reader	Negative
EX 2	1/7/02	4/14/03	Wiot/BCR, B-reader	Negative

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height**[15]	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**
DX 23 8/23/00	Not noted/ Not noted/ Yes	46/72.4"	2.782	3.764	113.6	73%	No[16]
DX 7 4/4/01	Good/Good/ Yes	47/72"	0.74 0.88*	1.16 1.18*	17	63% 74%*	Yes[17]
DX 18 7/2/01	Good/ Suboptimal/ Yes	47/72"	1.52	2.28	36	66%	Yes[18]

* post bronchodilator values

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_{2*}**	**pO_{2*}**	**Qualifying**
DX 7	4/04/2001	40	54	Yes
DX 18	7/02/2001	41.1	61.7	No
EX 4	1/07/2002	42.3	64.1	No

[15] I must resolve the height discrepancy recorded on the pulmonary function tests. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find that the miner's actual height is 72.5 inches.

[16] This study was found invalid by Dr. Burki because no flow volume loops were included and the spirometry curves indicated suboptimal effort. (EX 3). Dr. Burki is board certified in internal medicine and pulmonary disease.

[17] This study was found invalid by Dr. Burki due to suboptimal effort. (DX 8).

[18] Employer contends that the July 2, 2001 PFT was invalidated by Dr. Broudy. In his medical report, Dr. Broudy said that the "patient's effort appears to have been satisfactory." (DX 18). In his first deposition regarding this examination, Dr. Broudy states the PFT "results suggested a severe restrictive defect with no response to bronchodilatation." He makes no statements that the PFT test is invalid; in fact, he relies upon them for his diagnosis. Dr. Broudy states that his results are improved from that of Dr. Majmudar's, and yet still he makes no reference to invalidity. Finally, when asked directly about the validity of the PFT study, he states the following: "we did require multiple trials to get satisfactory results, but I believe that they were – it was within good studies." (DX 18). In his second report, Dr. Broudy specifically notes the invalidity of the second PFT dated January 7, 2002. (EX 4). In his initial deposition however, Dr. Broudy repeats his statement of the satisfactory effort of the July 2, 2001 PFT made on his initial report, but regarding the January 7, 2002 results, he states "the results are not valid because of variable and suboptimal effort." Nevertheless, Dr. Broudy eventually states that the July of 2001 study was invalid, but provides no reasoning as to why he changed his mind, even though in invalidating numerous other PFTs he always articulated his reasoning. I do not find that this constitutes a finding of invalidity as he provided no reasoning as to why it was invalid when he did for every other PFT, and he originally found the test to be valid numerous times.

Narrative Reports

Dr. Broudy examined Claimant on July 2, 2001 and provided a written report. (DX 18). At the time of the examination, Claimant was forty-seven years old. A smoking history of approximately twenty-six years at a three quarter pack a day is reported. Dr. Broudy considered thirty years and five months of underground coal mine employment, with Claimant ending employment in June of 2000. Claimant described his breathing trouble as becoming progressively worse since 1990, requiring oxygen therapy for the past four months. Claimant told Dr. Broudy he had been diagnosed with severe COPD, chronic bronchitis, and black lung.

Dr. Broudy noted that Claimant provided a history which suggested obstructive sleep apnea, along with a history of daily cough and sputum for numerous years. The cough is often accompanied with wheezing and swelling of the hands. Since quitting work, Claimant has "gained a lot of weight." There is no indication in the treatment record just how much weight Claimant gained, but Dr. Broudy describes Claimant as obese. Claimant can only walk approximately fifty feet on a flat surface before becoming breathless. He does not even try to walk upstairs and spends most of his time watching television.

The physical examination revealed that the chest excursion was diminished bilaterally and this improved when Claimant coughed. The lungs were clear to auscultation and percussion, but the breath sounds were diminished with no adventitial sounds. The objective PFT testing demonstrated a severe restrictive defect with no responsiveness to bronchodilation.[19] The ABG showed a moderately severe hypoxemia. Dr. Broudy believed the elevation of the carboxyhemoglobin indicated a continued exposure to smoke. The x-ray evidence as interpreted by Dr. Broudy showed simple coal workers' pneumoconiosis, category 1/0 qt.[20]

Dr. Broudy concluded the report by stating that he believed the evidence showed a finding of "early simple pneumoconiosis" and additional interstitial fibrosis. Based upon the PFT study, Claimant "clearly does not retain the respiratory capacity" to perform the work of a coal miner, or similarly arduous manual labor. Nevertheless, Dr. Broudy opined that the level of pulmonary impairment shown on the PFT could not be solely caused by the level of pneumoconiosis shown on the x-ray, but he never provided an explanation as to what the cause might be.

Dr. Broudy was also deposed regarding this examination on October 9, 2001. (DX 18). He noted that Claimant's chronic lung disease was substantially aggravated by his thirty year history of coal mine employment. Dr. Broudy noted the radiographic evidence suggesting pulmonary fibrosis was not the type normally seen with coal workers' pneumoconiosis and silicosis. The pulmonary function testing showed a severe restrictive defect with no response to bronchodilation, which according to Dr. Broudy was more severe than he would have expected given Claimant's mild pneumoconiosis.[21] Dr. Broudy noted Claimant's surgical history,[22]

[19] Dr. Broudy noted a satisfactory effort on the testing.
[20] Dr. Broudy also stated he saw additional interstitial scarring not classified as small linear or small rounded opacities on the x-ray film.
[21] Dr. Broudy went on to state these vents were valid. (DX 18 – pg.18 of transcript).
[22] Claimant suffered a motor vehicular accident in which he had a laparotomy with removal of his spleen, part of his pancreas, and one rib.

smoking history and obesity would also contribute to the severe restrictive defect. It was also noted the blood gasses showed hypoxemia with elevation of carboxyhemoglobin.

Dr. Broudy again examined Claimant on January 7, 2002 and issued a report. (EX 4). Claimant was forty-eight years old at the time of the examination. Smoking history was listed as being about three to four cigarettes a day for approximately twenty-seven years (and still smoking), and Dr. Broudy considered thirty years of underground coal mine employment. Dr. Broudy noted Claimant has a long history of breathing trouble, beginning in 1990 and progressively worsening to the point of needing oxygen since April 2001. Claimant informed Dr. Broudy that his breathing troubles have not changed since July. Claimant's wife described classic symptoms of obstructive sleep apnea. Dr. Broudy noted that Claimant complains of fitful breathing at night with periods of heavy respiratory efforts. Dr. Broudy again noted Claimant's history of dyspnea with minimal exertion and wheezing.

The physical examination showed Claimant to be obese with a short neck. The chest expansion was diminished with clear, but shallow respirations. The PFT was performed with "variable effort." Dr. Broudy interpreted the results as showing significant improvement after bronchodilation, which he stated may simply be the result of better effort.[23] Nevertheless, Dr. Broudy invalidated the results due to variable and suboptimal effort. The ABG revealed a moderate hypoxemia with an elevation of the carboxyhemoglobin – which Dr. Broudy stated indicated a continued exposure to smoke. Dr. Broudy interpreted the x-ray to show an increase in interstitial opacities in the mid and lower zones which he categorized as category 0/1qt under the ILO classification system.[24]

Dr. Broudy concluded by stating the current evidence did not support a diagnosis of coal workers' pneumoconiosis. Without a valid PFT, Dr. Broudy stated it would be hard to judge Claimant's respiratory capacity – but thought it doubtful that Claimant could perform his previous coal mine work, or work of similar demand in a dust free environment. While Dr. Broudy opined that there is no evidence that Claimant suffers from a significant pulmonary disease or respiratory impairment which has arisen from Claimant's coal mine employment, he diagnosed chronic bronchitis, obstructive sleep apnea, obesity, and hypertension. Ultimately, Dr. Broudy stated there was no evidence of change in Claimant's condition since his previous examination in July of 2001.

Dr. Broudy was deposed on February 25, 2003. (EX 4). Dr. Broudy stated that based upon his review of the entire medical record before him, he believed Claimant suffered from simple pneumoconiosis brought on by exposure to coal dust. However, Dr. Broudy stated that the "best studies" showed only a mild restriction which would be due to a combination of factors, including interstitial lung disease and obesity. He based this upon the fact that the best studies exceeded the federal minimum for total disability. Dr. Broudy also opined that both his July 2001 PFT and the January 2002 studies were both invalid. However, Dr. Broudy never stated why he believed his study of July 2001 was invalid.

[23] Dr. Broudy also notes the PFT results are considerably better than the results obtained in July of 2001.
[24] Dr. Broudy noted he did not have the previous film available for comparison.

Dr. Chavda, Claimant's treating physician, was deposed on Hopkinsville, Kentucky on July 3, 2003.[25] He began by noting that he began treating Claimant in 1999 for his pulmonary impairment and still treated Claimant at the time of the deposition.[26] Claimant was diagnosed with COPD, pneumoconiosis, and chronic bronchitis. He based his diagnosis of pneumoconiosis based upon x-ray readings, history of coal dust exposure, daily symptoms, coughing, wheezing, shortness of breath, and pulmonary function study testing.[27] Since April of 2000, Claimant has been on oxygen twenty-four/seven at Dr. Chavda's orders due Claimant's low oxygen level.

Dr. Chavda also noted that he had the opportunity to view Claimant informally during office visits and stated his demeanor was consistent with his physical complaints made during the examinations. Having considered Claimant's physical limitations, lung conditions, and hypoxia, Dr. Chavda opined Claimant would not have the pulmonary capacity to perform coal mine work. Dr. Chavda noted that ABG testing conducted after Claimant was put on oxygen, even if he was off the oxygen a few hours before, might give higher test results than had he been off the oxygen.[28]

On cross examination, Dr. Chavda acknowledged that the PFT testing conducted on April 4, 2001 exceeded the five percent variation requirement under § 718 Appendix B.[29] Furthermore, Dr. Chavda noted that while Claimant has a twenty year smoking history and suffers from morbid obesity, those factors alone would not account for his current lung condition.[30] Dr. Chavda emphasized the importance of looking at the entire picture of a patient to make a diagnosis – and in this case – the entire picture showed a coal dust induced lung disease, even without considering the PFT testing.

Treatment Records[31]

The record includes treatment records that include the following:[32]

[25] Dr. Chavda's vitae, which is attached to the deposition, shows he is board certified in both internal and pulmonary medicine.
[26] His records indicate Dr. Chavda saw Claimant once every two or three months, for a total number of fifteen visits for pulmonary treatment.
[27] The x-ray readings not conducted as a part of the OWCP exam were not given an ILO classification.
[28] Dr. Chavda opined that error was unlikely in his ABG test of April of 2001 – as an error in an ABG test usually only results in higher PO2, because of the chance an air bubble might be in the tube, and thus increase the oxygen count.
[29] He also conceded that other PFTs conducted at his office do not have all three tracings.
[30] He also noted that no doctor in the world has the capacity to differentiate between the impairments caused by pneumoconiosis and smoking – when both are involved.
[31] Included in the treatment notes are x-ray reports from several physicians. There is no evidence in the record as to the x-ray reading credentials of these physicians. §718.102(c). Also, these interpretations were all related to the treatment of Claimant's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. In addition, there is no record of the film quality for any of these x-rays. §718.102(b). Finally, the interpreting physicians did not provide an ILO classification for their readings. §718.102(b). As a result, these x-ray interpretations are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Therefore, I accord the x-ray interpretations contained in the treatment records no weight for the purpose of determining whether Claimant suffers from pneumoconiosis under § 718.202(a)(1).
[32] Treatment records are located at DX 23.

-April 15, 1996 x-ray reading of Dr. Emery Lane as 1/0pp reading.[33]

-April 30, 1996 x-ray report of Dr. Emery Lane

-August 23, 2000 examination report of Dr. Richard Goldwin[34] conducted at the University of Louisville Hospital. This examination included an x-ray report,[35] employment history, personal history, physical examination, PFT (pre and post-bronchodilator), ABG, diffusion capacity, and an EKG. Dr. Goldwin concluded by stating that Claimant suffers from pneumoconiosis and COPD. He stated the pneumoconiosis was evidenced by radiographic evidence, and the COPD as shown through the PFT is most "likely related to [the] long history of cigarette smoking." As I have ruled the x-ray inadmissible, and it is all Dr. Goldwin relies on in his diagnosis, I place no weight on his diagnosis of pneumoconiosis. As far as diagnosing COPD due to cigarette smoking, Dr. Goldwin provides no logical reason as to why smoking is the sole etiology and how he can rule out thirty plus years of coal mine employment as a contributor. As such, I find his etiology finding surrounding the COPD to be unreasoned and accord it little weight.

Medical records dating from February 25, 1999 through September 25, 2000 from Claimant's treating physician, Dr. Sanjay Chavda at the Western Kentucky Pulmonary Clinic:

-February 25, (no year noted; most likely 1999) x-ray report from Dr. Chavda which noted a "bilateral increase (something illegible) suggestive of pneumoconiosis."

-February 25, 1999 PFT results showing an FVC of 1.92 (2.23 post), an FEV1 of 1.44 (1.41 post) for an FEV1/FVC ratio of 75 (63 post). The report notes the FVC is thirty-five percent of predicted and FEV1 is thirty-six percent of predicted – with a ratio of seventy-five. Dr. Chavda notes the flow volume loop is suggestive of severe obstructive airway disease.

-February 25, 1999 initial consultation report of Dr. Chavda with Claimant. Claimant sought treatment because his breathing is getting worse, he is coughing a lot, and he constantly feels short of breath. It is noted that his coughing gets to the point where it causes dizziness and nearly causes Claimant to pass out. Sometimes, the cough is accompanied with chest pains. Claimant's family and work history (thirty years of coal mine employment) are listed. The physical exam revealed that the lungs showed no dullness on percussion with good air entry bilaterally and no wheezing or crackles. A smoking history of twenty years with a half a pack to a pack a day is noted.

-March 25, 1999 follow up note for treatment of severe shortness of breath. Dr. Chavda notes an extensive history including thirty years of coal mine employment. It is noted that Claimant was thinking of quitting his job because his breathing very bad – and being in the coal mines makes his breathing difficulties increase. Being around coal dust makes Claimant suffocate. Coughing spells are listed as lasting up to three minutes, sometimes causing him to nearly pass out. Claimant is described as not having the capacity to climb even one flight of stairs. The physical exam of Claimant's lungs revealed good air entry bilaterally with no wheezing or crackles.

[33] Dr. Lane checked that she is neither a BCR nor a B-reader. This x-ray has been deemed inadmissible. *Supra* at 5.
[34] Dr. Goodwin is both a Board Certified Radiologist and a B-reader.
[35] This x-ray was deemed inadmissible. *Supra* at 5.

-May 18, 2000 treatment note concerning severe shortness of breath. Dr. Chavda conducted a PFT which revealed severe obstructive and restrictive airway disease. It is noted that at the mines it was getting difficult for Claimant to do any exertion – even moving five pounds of weight. Even such an activity gave him shortness of breath. This is sometimes accompanied with extreme choking. His cough is now daily and sometimes gets severe enough to cause dizziness.[36]

-May 30, 2000 generic note "to whom it may concern" stating Claimant has severe pneumoconiosis and severe COPD, which renders his lung function to be very poor. The shortness of breath increases at work places from exposure to coal dust. It is the doctor's medical advice that Claimant no longer work in coal mines from this date forward.

-July 18, 2000 treatment note noting shortness of breath occurring at night with difficulty breathing. The physical exam revealed poor air entry with wheezing and crackling.

-September 25, 2000 follow up note noting shortness of breath with the physical examination revealing poor air entry into the lungs with wheezing on both sides and a few crackles.

Medical records attached to Claimant's deposition from Dr. Chavda at the Western Kentucky Pulmonary Clinic dated through May 21, 2003.[37]

-November 20, 2000 follow up note stating that the cold weather is helping Claimant's breathing, as warm weather and humidity make it worse. Claimant still has trouble breathing when climbing or walking uphill. The physical examination reveals poor air entry into the lungs with a few crackles at the bases but no wheezing.

-February 20, 2001 a follow up note only containing the second page. This only includes some of Claimant's prescriptions and the treatment plan.

-April 4, 2001 follow up note addressing shortness of breath. The physical examination reveals good bilateral breath sounds with no significant wheezing.

-April 17, 2001 follow up note addressing continuing COPD, pneumoconiosis, and hypertension. The hypoxia diagnosed with the OWCP exam is discussed and the fact Claimant is now on home oxygen. The physical examination reveals "fair" air entry to the lungs with no significant wheezing or crackling. The overall continuing impression was that of pneumoconiosis, severe COPD, cor pulmonale, hypertension, chronic hypoxia, and significant obstructive sleep apnea.

-June 18, 2001 follow up note addressing Claimant's continuing breathing trouble. Physical exam reveals good air entry with no wheezing or crackling.

[36] This PFT does not contain three tracings, and is therefore not valid for determining total disability.
[37] These treatment records are located at CX 1. Some of the records are copies of those submitted under DX 23. Summaries will not be repeated.

-September 18, 2001 follow up note where Claimant came in for treatment of a back and leg injury he received while lifting a heavy object at home. Physical exam reveals good air entry with no wheezing.

-December 18, 2001 follow up note for treating shortness of breath. Dr. Chavda describes Claimant as being "totally disabled."[38] Dr. Chavda lists Claimant's present illnesses as pneumoconiosis, severe COPD, chronic bronchitis, hypertension, and severe obesity. Physical exam shows poor air entry into both lungs with prolonged expiration and mild wheezing.

-March 19, 2002 follow up note for shortness of breath, loss of sleep, and daytime fatigue. Dr. Chavda lists pneumoconiosis, obesity, severe COPD, and significant obstructive sleep apnea. The physical examination of the lungs revealed fair air entry with no wheezing or crackling.

-June 25, 2002 follow up note for loss of weight. Dr. Chavda lists pneumoconiosis, COPD, hypertension, and chronic bronchitis are listed as present illnesses.

-September 30, 2002 follow up note for treating Claimant's coughing. Physical exam reveals poor air entry to both lungs, but no wheezing or cracking is present.

-December 2, 2002 follow up note for treating fatigue and shortness of breath from walking. Dr. Chavda notes under history of present illness that Claimant suffers from pneumoconiosis, pulmonary fibrosis, COPD, hypertension, and obesity. Physical exam shows prolonged expirations with poor air entry. Mild wheezing and crackles are noted on both sides.

-December 2, 2002 PFT study showing an FVC of thirty-one percent, and FEV1 of twenty eight percent of predicted values. The FEV1/FVC ratio is seventy-two. Post-bronchodilator shows no significant change. Dr. Chavda's overall impression of the study was that it revealed severe obstructive and restrictive airway disease.

-December 20, 2002 Sleep Study Report by Dr. Chavda.

-January 10, 2003 follow up note for using a nasal CPAP[39] and sleep apnea study. The study reveals that Claimant stopped breathing 185 times and his apnea/hypopnea index is thirty-eight. He has been using the CPAP for twenty-three days for an average of seven and a third hours per night. Claimant states that this provides him with much more energy. Physical exam of the lungs reveals wheezing. Final impressions are severe obstructive sleep apnea, obesity, and pneumoconiosis.

-February 21, 2003 follow up note for treating a pain in Claimant's leg. Dr. Chavda notes Claimant has severe obesity, obstructive sleep apnea, COPD, bronchitis, and pneumoconiosis.

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[38] He does not appear to be offering a legal conclusion under § 718.204, but rather seems to be stating Claimant's pulmonary condition has taken away his ability to function on almost any level.

[39] Dr. Chavda does not describe what CPAP is. The American Academy of Otolaryngology describes it as Continuous Positive Airway Pressure. The machine delivers air into a person's airway through a specially designed mask or pillows while he/she sleeps. *See* http://www.entnet.org/healthinfo/snoring/cpap.cfm. (Accessed March 23, 2007).

-May 21, 2003 treatment note from Dr. Majmudar[40] for COPD. Claimant denied any recent cough or sputum production. Claimant's breathing machine information was downloaded and showed he was extremely compliant – with eight and a half hours a day with one-hundred percent compliance. The physical examination revealed good bilateral breath sounds with no significant wheezing.

Smoking History

As my previous conclusion has not been challenged, I incorporate my previous finding that Claimant has twenty pack years.[41]

DISCUSSION AND APPLICABLE LAW

This claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202), and

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

   (iii) Is totally disabled (see § 718.204(c)), and

   (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994).

[40] Dr. Majmudar is Dr. Chavda's office partner at the Western Kentucky Pulmonary Clinic.
[41] The reports varied greatly as to Claimant's smoking history, ranging from twenty to twenty-five years. I shall accord Claimant the benefit of the doubt and accord him with twenty pack years.

Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

(1) Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis. Under § 718.202(a)(1), one method for finding that pneumoconiosis exists is the use of x-ray evidence.

In this claim the record contains interpretations of three different x-rays. The x-ray taken on April 4, 2001 was interpreted positive for pneumoconiosis by Dr. Majmudar, who holds no qualifications. Dr. Sargent, who is both BCR certified and a B-reader interpreted the film as quality three – which renders the x-ray unreadable. Dr. Wiot, who is also BCR certified and a B-reader interpreted the film as quality three. If a film's quality is poor or unreadable, then the study may be given little or no probative value as it is very poor quality. *Gober v. Reading Anthracite Co.*, 12 B.L.R. 1-67 (1988). Given the superior credentials of both Drs. Sargent and Wiot, I find this x-ray to be unreadable and accord it no weight.[42]

[42] The District Director is required to provide each miner applying for benefits with the "opportunity to undergo a complete pulmonary evaluation at no expense to the miner." § 725.406(a). A complete evaluation includes a report

Dr. Wiot read the July 2, 2001 and January 7, 2002 x-rays and found both of them to be completely negative. He considered both films to be quality one. Because of Dr. Wiot's credentials and because his readings are not contradicted, I consider both of these x-rays negative.[43]

In this case, I find the two negative readings by Dr. Wiot to outweigh the positive reading of an unreadable x-ray by Dr. Majmudar. Accordingly, I conclude that the x-ray evidence does not support the existence of pneumoconiosis pursuant to § 718.202(a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. That method is not available in the instant case because this record contains no biopsy evidence.

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis; § 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

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of the physical examination, a chest x-ray, a pulmonary function study, and an arterial blood gas study. Reviewing courts have added to this burden by requiring the pulmonary evaluation be sufficient to constitute an opportunity to substantiate a claim for benefits. *See Petry v. Director*, OWCP 14 B.L.R. 1-98, 1-100 (1990)(*en banc*); *see also Newman v. Director*, OWCP, 745 F.2d 1161 (8th Cir. 1984); *Prokes v. Mathews*, 559 F.2d 1057, 1063 (6th Cir. 1977).

In this Decision and Order, I have found that Claimant's x-ray is unreadable for purposes of determining pneumoconiosis as noted above. As a result, even if this claim were remanded to the Director to provide another x-ray concerning the existence of pneumoconiosis, Claimant could not prevail as two x-rays read by a doctor with both BCR and B-reader credentials exists. Furthermore, the existence of pneumoconiosis has been established by a reasoned medical opinion. Therefore, I find that remand of this case would be futile. *Larioni v. Director, OWCP*, 6 B.L.R. 1-1276 (1984); *see*, *e.g.*, *Mullins v. Director, OWCP*, No. 05-0295 BLA (BRB, Jul. 27, 2005)(unpub.); *Bowling v. Director, OWCP,* No. 05-0327 BLA (BRB, Jul. 29, 2005)(unpub.).

[43] Claimant did not designate any rebuttal to these submissions. However, Dr. Broudy read the July 2, 2001 x-ray as positive for pneumoconiosis. Dr. Broudy holds B-reader credentials, but is not board certified. Given Dr. Wiot's superior credentials, had Claimant submitted Dr. Broudy's interpretation, I still would have found this x-ray negative. Dr. Broudy considered the January 7, 2002 x-ray to be 0/1 – which is negative. Thus, the preponderance of the x-ray evidence would still be considered to be negative.

This section requires a weighing of all relevant medical evidence to ascertain whether or not Claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985).

In providing Claimant's OWCP evaluation, Dr. Majmudar diagnosed COPD, chronic bronchitis, and sleep apnea. Dr. Majmudar opined that these conditions were a result of Claimant's coal mine employment and cigarette smoking. Dr. Majmudar stated the symptoms of the patient, the PFT, and the x-ray were the basis for the above diagnoses. However, Dr. Majumdar relied upon an x-ray that was determined to be unreadable, and a PFT which has been deemed invalid. Thus, because the only evidence left in coming to his conclusion was based upon this one time physical examination, I only accord his opinion little weight.

Dr. Broudy provided two separate medical opinions and I shall address each individually. In the opinion dated July 2, 2001, Dr. Broudy opined that Claimant suffered from a form of early simple coal workers' pneumoconiosis, and that this chronic lung disease was substantially aggravated by Claimant's thirty years of coal mine employment.[44] Dr. Broudy provides no other reasoning for his diagnosis of pneumoconiosis outside of his x-ray reading. The Sixth Circuit Court of Appeals has held that merely restating an x-ray is not a reasoned medical judgment under § 718.202(a)(4). *Cornett v. Benham Coal, Inc*., 227 F.3d 569 (6th Cir. 2000). The Board has also explained that, when a doctor relies solely on a chest x-ray and coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his opinion "merely a reading of an x-ray . . . and not a reasoned medical opinion." *Taylor v. Brown Bodgett, Inc*., 8 B.L.R. 1-405 (1985). Thus, I find his diagnosis of coal workers' pneumoconiosis in the July 2, 2001 report unreasoned and accord it little weight. Dr. Broudy made no other pulmonary diagnoses in this report or in his deposition.

The second opinion of Dr. Broudy's was written on January 7, 2002. Dr. Broudy diagnosed chronic bronchitis and sleep apnea. This time, he intimated there was not enough evidence to support a diagnosis of coal workers' pneumoconiosis. This was apparently based upon a negative x-ray. However, despite evidence that Claimant suffers from a pulmonary condition, Dr. Broudy fails to articulate any form of etiology which might be responsible for Claimant's condition (chronic bronchitis). He simply states "there is no evidence of any chronic lung disease caused by the inhalation of coal mine dust." Furthermore, he fails to explain how over thirty years of coal dust exposure does not play a role in Claimant's breathing impairment. He simply states there is not enough evidence to conclude that pneumoconiosis *exists*. I find this to be unreasoned as he fails to provide any etiology or explanation of Claimant's current condition.

[44] Outside pneumoconiosis, Dr. Broudy made no other pulmonary diagnoses which he attributed to coal mine employment.

In the deposition following this report, Dr. Broudy believed the entire medical record he reviewed, which included medical records from Dr. Chavda and Dr. Broudy's previous examinations, showed Claimant suffered from simple pneumoconiosis.[45] In this, he considered numerous x-rays and PFTs which have been deemed either invalid or are not a part of the record. However, Dr. Broudy never stated in his deposition upon what evidence he considered in drawing his conclusion that Claimant suffered from simple pneumoconiosis, nor did he provide any reasoning. He simply offered a conclusion. Thus, I find the report vague and unreasoned as Dr. Broudy did not indicate which evidence he relied on – nor did he clarify how he changed his conclusion issued in the January 7, 2002 report. As such, the report dated January 7, 2002 shall be given little weight.

The final opinion comes from Dr. Chavda, Claimant's treating physician. The Board instructed that I should note what inadmissible evidence he considered and weigh his opinion accordingly under *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004)(*en banc*). *Supra* at 4. In his deposition, Dr. Chavda stated he examined, among other things, the following pieces of evidence: 1) An x-ray reading taken in his own office in 1999; 2) a February 25, 1999 PFT; 3) University of Louisville examination conducted on August 23, 2000; 4) an April 2001 PFT; and 5) and an ABG conducted in July 2001 by Dr. Broudy. Furthermore, the treatment records attached to the deposition include PFTs conducted by Dr. Chavda dated May 18, 2000, and December 2, 2002. These tests were not discussed in the deposition. All the PFTs listed in the above paragraph either do not contain the correct number of tracings, or have been invalidated due to suboptimal effort. Nevertheless, even when one takes all this into account, Dr. Chavda still had the opportunity to examine Claimant over twenty times. In his deposition Dr. Chavda noted that even just looking at Claimant's physical condition deteriorate over the years, it is clear from the physical evidence that Claimant suffers from pneumoconiosis. Also, Dr. Chavda was able to look at Claimant's pulmonary impairment in light of his smoking history and obesity and stated that the impairment was too severe to be caused by these two things alone. Given that Dr. Chavda relied heavily upon his more than twenty visits with Claimant than on the objective testing that does not meet every criteria set forth under the Regulations, I accord Dr. Chavda's opinion probative weight.

In looking at the medical narrative evidence as a whole, I find Claimant's treating physician's (Dr. Chavda) testimony to be the most persuasive as he examined Claimant numerous times, and Dr. Broudy's testimony is unreasoned. As such, I conclude that the medical opinion evidence establishes the existence of pneumoconiosis under § 718.202(a)(4). *Perry v. Director, OWCP*, 9 BLR 1-1 (1986).

Upon consideration of all the evidence under § 718.202(a), I find the medical opinion evidence more persuasive than the x-ray evidence alone. The medical evidence is based upon numerous examinations by Claimant's treating physician that took place over a five year period of time. Consequently, I find that Claimant has established the existence of pneumoconiosis.

[45] I note that Dr. Broudy merely read his reports into the record. This is not testimony as articulated under § 725.414. As I have deemed his January 11, 2002 report to be inadmissible, and this is merely an attempt to get this report into evidence, I shall not consider that portion of the deposition.

Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). As I have found that Claimant has established thirty years of coal mine employment, he is entitled to the rebuttable presumption set forth in § 718.203(b) that his pneumoconiosis arose out of coal mine employment. While at one point, Dr. Broudy did opine that Claimant did not have a pulmonary impairment which arose out of coal mine employment,[46] he failed to articulate how he came to this conclusion, why his previous conclusions that Claimant's pneumoconiosis arose out of coal mine employment were incorrect, and what objective evidence he relied on in coming to this conclusion. Thus, Dr. Broudy's opinion is vague and equivocal. As such, I find employer has failed to present evidence to rebut the presumption afforded to Claimant at § 718.203(b).[47]

Total Disability

Claimant must also establish that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under § 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

I have determined that Claimant has not established that he suffers from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. There are four PFTs in evidence. The August 23, 2000 study did not produce values equal to or below those found in Appendix B of Part 718. It was also found invalid by Dr. Burki due to suboptimal effort. The three remaining studies, dated April 4, 2001, May 16, 2001, and July 2, 2001 yielded qualifying values. However, The April 4, 2001 and the May 16, 2001 tests were invalidated by a reviewing physician. Dr. Burki declared the April and May 2001 studies invalid because of suboptimal effort. As noted above, I considered the testimony evidence to establish the July 2, 2001 study as valid.[48] As only there is only one PFT study that is valid, and it produced qualifying values, I therefore find that Claimant has established the existence of total disability under subsection (b)(2)(i).

[46] Dr. Broudy provided different conclusions in each report – and his deposition testimony stated that coal mine employment did contribute to Claimant's pulmonary impairment.

[47] I also note that Dr. Chavda stated that both cigarette smoking and coal mine employment played a role in Claimant's condition. He stated "no doctor can differentiate that pneumoconiosis and the smoking, what part is caused by smoking and part what caused by pneumoconiosis. There is no doctor in the world – no test in the world can differentiate [between the two] at this time." (CX 1).

[48] *See supra* n. 18.

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of arterial blood gas studies meet the requirements listed in the tables found at Appendix C to Part 718. There are three ABGs in evidence. The earliest ABG conducted on April 4, 2001 produced qualifying values. At this point, Claimant's treating physician put Claimant on oxygen to treat hypoxemia. The next two ABGs produced values just above the qualifying levels. However, Claimant's deposition testimony establishes that he had only been off the oxygen for about five minutes before taking these ABGs. (DX 17). Dr. Chavda noted that the reason the values of these two tests were higher than his were because Claimant's system was inundated with pure oxygen just before testing.[49] As the values of the last two ABGs are only just above qualifying after Claimant was on pure oxygen only minutes before the tests, and the April 4, 2001 ABG produced qualifying values, I find that Claimant has established total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant's usual coal mine employment involved working as a fire boss and a pump man.

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

Drs. Chavda and Majmudar opined that Claimant does not retain the pulmonary capacity to work as a coal miner. Dr. Chavda has treated Claimant since 1999. At the time of his deposition in July 2003, he had seen Claimant on almost twenty separate occasions. Dr. Chavda is a pulmonary specialist who treats Claimant for his respiratory problems. He conducted numerous physical examinations and had the opportunity to view Claimant's pulmonary capacity first hand. Based on these factors, I consider Dr. Chavda to be Claimant's treating physician

[49] Dr. Chavda noted even if Claimant had been off the oxygen for a few hours – it would produce higher results than if Claimant had been off oxygen entirely.

under § 718.104(d). I also find that Dr. Chavda's opinion is well documented and reasoned as he had the opportunity to view Claimant multiple times and even saw him informally in the office.[50] *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). Although there is some conflicting proof in the record, I find that Dr. Chavda's opinion, which is bolstered at least in part by the other medical opinions, is entitled to probative weight. § 718.104(d)(5).

Dr. Majmudar's opinion is clearly based in part on the invalidated pulmonary function study he administered. However, Dr. Majmudar also relied upon presenting symptoms of shortness of breath and sputum production to make his determination of total disability. Accordingly, I do not completely discount his opinion, but rather only place some weight on it.

Dr. Broudy's first opinion stated that Claimant was totally disabled from a pulmonary standpoint. (DX 18). He noted that Claimant "clearly does not retain the respiratory capacity to perform the work of an underground coal miner or to do similarly arduous manual labor." This opinion rested in part upon the PFT conducted during this first visit.[51] However, Dr. Broudy also made this finding based upon his physical examination, an ABG showing moderate hypoxemia, and Claimant's history. As Dr. Broudy relied upon objective evidence in coming to this conclusion, I find this opinion to be well documented and well reasoned and place probative weight on it.

In his second opinion from the January 7, 2002 examination, Dr. Broudy stated that Claimant was in fact not totally disabled, nor did Claimant suffer from pneumoconiosis. (EX 4). Dr. Broudy opined that the PFT conducted on this date was invalid due to poor effort. The physical exam revealed a diminished chest expansion with clear lungs, but shallow respirations. Dr. Broudy stated that it is "doubtful whether he [Claimant] would retain the respiratory capacity to perform the work of an underground coal miner or to do similarly arduous manual labor." He also stated "there is no evidence that there has been any substantial change in his condition since the previous examination" when he diagnosed total disability. This would seem to indicate Dr. Broudy believed Claimant was totally disabled. But in his deposition, Dr. Broudy stated that the best studies would suggest that Claimant retained the capacity to perform the work of a coal miner. It appears as though the "best studies" that Dr. Broudy relied on were from Dr. Mallampalli's PFT conducted on August 23, 2000.[52] Employer submitted evidence indicating, and I found that, this PFT study is invalid.[53] Because Dr. Broudy is both equivocal and vague and relies heavily upon inadmissible evidence in drawing his conclusion on total disability, I accord his second opinion on this issue little weight.

In this section, I find the treatment records and deposition testimony of Dr. Chavda to be most persuasive as Dr. Chavda had the opportunity to view Claimant numerous times. As such, I find Claimant has established total disability under § 718.204(b)(2)(iv).

[50] Dr. Chavda stated that even had he not considered the PFTs which have been deemed invalid, he still would consider Claimant to be totally disabled simply based upon the physical findings. (CX 1).
[51] I have determined this PFT to be valid. *See supra* n. 18.
[52] *See* EX 4 at p.30 & p. 36 where Dr. Broudy noted this was the only valid PFT study before him.
[53] *See supra* n. 16.

Based on my review of the medical opinion evidence, I find the Claimant has established total pulmonary disability or total disability due to pneumoconiosis under § 718.204(b)(iv).[54] I find the medical opinion evidence to be the most probative of Claimant's ability to work as a coal miner. Those reports are supported by the blood gas studies of record and the only valid PFT in evidence. Accordingly, I find that Claimant has established that he suffers from a totally disabling pulmonary condition.

Total Disability due to Pneumoconiosis

Claimant must also establish that his total disability is due to pneumoconiosis by a preponderance of the evidence. *Baumgartner v. Director, OWCP*, 9 BLR 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 BLR 1-4, 1-6 (1986) (en banc). In *Grundy Mining Co. v. Director, OWCP [Flynn]*, 353 F.3d 467 (6th Cir. 2003), the Sixth Circuit set forth the standard for establishing that a miner's total disability is due to pneumoconiosis:

> The claimant bears the burden of proving total disability due to pneumoconiosis and . . . this causal link must be more than *de minimus*. (Citation omitted). To satisfy the 'due to' requirement of the BLBA and its implementing regulations, a claimant must demonstrate by a preponderance of the evidence that pneumoconiosis is 'more than merely a speculative cause of his disability,' but instead 'is a contributing cause of some discernible consequence to his totally disabling respiratory impairment.' (Citation omitted). To the extent that the claimant relies on a physician's opinion to make this showing, such statements cannot be vague or conclusory, but instead must reflect reasoned medical judgment. (Citation omitted).

Dr. Chavda attributed the miner's disability to both coal mine dust exposure and smoking. He stated that it was impossible to differentiate between the two, but he could state for certain that Claimant's obesity and smoking history could not account for the totality of Claimant's current pulmonary impairment. This constitutes a finding that coal dust exposure contributed to Claimant's pulmonary impairment under *Crockett Collieries, Inc. v. Director, OWCP [Barrett]*, __ F.3d __, Case No. 05-4188 (6th Cir. Feb. 16, 2007) (J.Rogers, concurring). This opinion is well reasoned and well documented. As Dr. Chavda is also Claimant's treating physician, his opinion is entitled to substantial probative weight. Dr. Majmudar opined that pneumoconiosis is a significant contributor to Claimant's impairment. In Dr. Broudy's first deposition he stated that obesity, smoking, and coal dust exposure played a role in Claimant's totally disabling pulmonary impairment and that Claimant in fact had a coal dust induced lung disease which was "substantially aggravated by his thirty years of exposure to coal mine employment." However, in his second opinion, he stated that Claimant is not even totally disabled by pneumoconiosis, but failed to articulate how he can change his mind from his

[54] I would like to note that had I considered all the PFTs of record to be invalid, I still would have found total disability based upon the medical opinion evidence as well as the ABG studies. This includes the fact that Dr. Broudy's first opinion would have been discounted for relying on the "invalid" PFT.

previous findings other than relying on a PFT which has been deemed invalid. As this opinion is contrary to my finding on total disability, I accord his opinion on this issue little weight.

Here, I find Dr. Chavda's opinion most persuasive as he viewed Claimant a number of times. Dr. Chavda clearly articulated how Claimant's conditions of obesity and smoking history would not account for the totality of Claimant's current pulmonary impairment and how the thirty years of coal mine employment played a significant role. Consequently, I find that Claimant has established that his total respiratory disability is due at least in part to his pneumoconiosis under § 718.204(c).

Entitlement

As the evidence establishes that Claimant is totally disabled due to pneumoconiosis, I find that he is entitled to benefits under the Act. Benefits are payable beginning with the month of onset of total disability due to pneumoconiosis rising out of coal mine employment. § 725.503(b). Where the evidence does not establish the month of onset, benefits shall be payable to the miner beginning with the month during which the claim was filed. In this case, that is February 2001. Because I cannot determine from the record the exact date when Claimant became totally disabled due to his pneumoconiosis, benefits will commence February 1, 2001.

Attorney's Fees

No award of attorney's fees for services to Claimant is made herein, since no application has been received from counsel. A period of thirty days is hereby allowed for Claimant's counsel to submit an application, with a service sheet showing that service has been made upon all parties, including Claimant. The Parties have ten days following receipt of any such application within which to file their objections. The Act prohibits the charging of any fee in the absence of such approval. *See* §§ 725.365 and 725.366.

ORDER

It is therefore ORDERED that the claim of R.B. for benefits under the Act is GRANTED. Pleasantview Mining Company, Inc. is hereby ORDERED to pay benefits to Claimant beginning with the date of February 1, 2001.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013- 7601. *See* 20 C.F.R. §§ 725.478 and 725.479. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).